

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03888

Reg. Dist. No. 116

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Dorchester
 County: Cambridge
 City or town: Cambridge
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? _____

3. (a) FULL NAME

Barbara Bromwell

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: _____
 6.(c) If alive, give age: _____ years

7. Birth date of deceased (m., day, yr.) June 8 1939

8. AGE: Years 5 Months 10 Days 15 If less than one day hrs. _____ min. _____

9. Birthplace: Cambridge Md
 (Town, county, and state)

10. Usual occupation: nurse

11. Industry or business

FATHER 12. Name: Joe. Bromwell
 13. Birthplace: Madison Md

MOTHER 14. Maiden name: Nellie Allen
 15. Birthplace: Cambridge Md

16. Informant: Nellie Allen Bromwell
 Address: 4 Well St

17. Burial: Burial Date thereof: April 25 1945
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory: Waugh Cemetery
 Location: High St Cambridge Md

18. Funeral director: Levin Bussey
 Address: Cambridge Md

19. (Date rec'd by registrar) 4-25-45 1945 John Macf. M.D. Registrar
 (Date signed) 4-24-45

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Maryland County: Dorchester
 City or town: Cambridge
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 4 Well St

(If rural, give LOCATION)

2.(a) If veteran, name war: _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 1945 at 3:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 22 1945 to April 23 1945

and that I last saw her alive on April 23 1945

Immediate cause of death: Influenza Pneumonia

DURATION

4 days

Due to: _____

Due to: _____

Other conditions: _____

(Include pregnancy within 3 months of death)

Major findings of operations: _____

Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work? _____

23. SIGNATURE: Carroll M St. Clair M.D.

M. D. or other

Address: 810 N. Charles St. Date signed: 4-24-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *442*

03889 T

CERTIFICATE OF DEATH

Reg. Dist. No. *118*

1. PLACE OF DEATH:

County

City or town

*Dorchester**Salestone**Seafood Del Rd*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ida A. Darby

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*7**white**Meadow**Thomas H. Darby*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

May 5 1867

8. AGE:

Years

Months

9. (a) If less than one day

*78**91**7*

hrs.

min.

9. Birthplace

(Town, county, and state)

Dorchester Md

10. Usual occupation

11. Industry or business

12. Name

Arthur Wheatley

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

17. Address

(Burial, cremation, or removal, which)

Date thereof

(month) (day) (year)

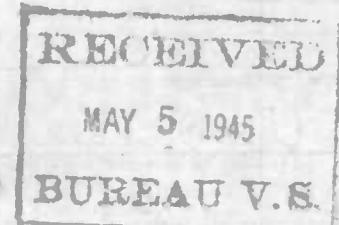
Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar



M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

03890

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester

Cambridge

City or town (If outside city or town limits, write RURAL and give nearest town)

Life

How long in above place of death?

Hospital, Institution, or street address where death occurred:

119 Rue du leau St.

How long in hospital or institution?

3. (a) FULL NAME

Aurelia E. Dashiell

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female

White

Single

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1861.

6. (c) If alive, give age

years

8. AGE: Years Months Days If less than one day

83

4

24

hrs.

min.

9. Birthplace: Nr. Cambridge, Dor. Co., Md.

(Town, county, and state)

10. Usual occupation Teacher

11. Industry or business Retired

12. Name: Edwin Dashiell

13. Birthplace: Maryland

14. Maiden name: Ellen Gordon

15. Birthplace: Not Known

16. Informant: Edwin D. Hirst

Address: Cambridge, Maryland.

17. Burial: Date thereof: April 6, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory: Christ Church Cemetery

Location: Cambridge, Maryland.

18. Funeral director: LeCompte's Funeral Service

Address: Cambridge, Maryland.

19. (Date rec'd by registrar)

4-6-45

19. 45

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland

County: Dorchester

City or town: Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No: 119 Rue du leau St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH: April 4 1945, at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on

19.

Immediate cause of death:

Exhaustion

Due to:

Carcinoma of Breast 8-10 p.m.

and metastasis into
chest and upper abdomen

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

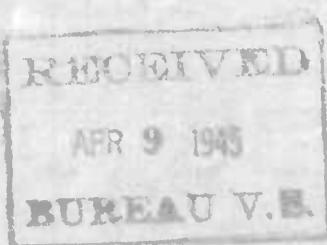
23. SIGNATURE

Dr. K. Shriver, Dep. Med. Exam.

M. D. or other

Address: Cambridge - Md. Date signed: April 5/45

VS A15



PLEASE WRITE PLAINLY, WITH UNTADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 121

03891

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County..... Dorchester

City or town..... Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred:

Cambridge-Md. Hospital, Inc.

How long in hospital or institution?

15 hours

3. (a) FULL NAME

Ethel Dayton

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Dec 1st 1905

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

40 4

hrs.

min.

9. Birthplace.....

Maryland

(Town, county, and state)

10. Usual occupation.....

Houseworks

11. Industry or business

Alvin Dayton

MOTHER FATHER

12. Name.....

Alvin Dayton

13. Birthplace.....

Maryland

14. Maiden name.....

Helen

15. Birthplace.....

Maryland

16. Informant.....

Hospital Records

Address.....

Cambridge

17. Burial (Burial, cremation, or removal) Date thereof.....

Burial

april 30 1945

(month) (day) (year)

18. Cemetery or crematory.....

Cemetery

19. Location.....

Cemetery

20. Funeral director.....

F. B. McLaughlin

Address.....

East New Market

21. Date rec'd by registrar.....

April 30 1945

22. Signature.....

John MacL. M.D.

23. M. D. or other

Cambridge Md.

Date signed.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Dorchester

City or town..... Cambridge (If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 28 1945 at 12:09 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 27 1945 to April 28 1945

and that I last saw her alive on April 27 1945

Immediate cause of death.....

Myocardial Failure

DURATION

2 days

Due to..... Peritonitis

?

Due to..... Ruptured Appendix

?

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

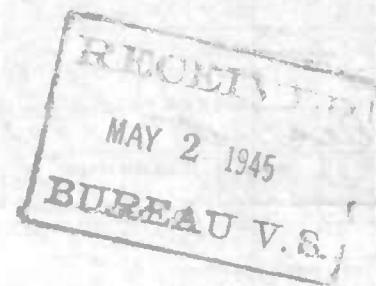
Means of injury.....

Injured at work?

23. SIGNATURE.....

John MacL. M.D. Cambridge Md. April 28 1945

Address..... Date signed.....



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *402*

CERTIFICATE OF DEATH

03892

Reg. Dist. No. 115

1. PLACE OF DEATH:

County *Oriental*City or town *Hooperville*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *days*

Hospital, Institution, or street address where death occurred:

Home

How long in hospital or institution?

*days*3. (a) FULL NAME *William Edward Dorsey*on Social Security card - name is *William H. Dorsey*4. Sex *Male* 5. Color or race *colored* 6. (a) Single, married, widowed, or divorced *Married*8. (b) Name of husband or wife *Katie A. Dorsey*7. Birth date of deceased (mo. day, yr.) *July 1885* 8. (c) If alive, give age *59* years8. AGE: Years *59* Months *9* Days *22* If less than one day *hrs.* *min.*9. Birthplace *Hooperville Md.* (Town, county, and state)10. Usual occupation *Salmon*11. Industry or business *Seafood & Salmon Packer*12. Name *Bill Dorsey*13. Birthplace *Maryland - Church Creek -**Phoebe Ross*14. Maiden name *Phoebe Ross*15. Birthplace *Hooperville Md.*16. Informant *Katie A. Dorsey*Address *Hooperville, Md.*17. Burial *Burial* Date thereof *April 29-1945*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Cemetery*Location *Hooperville, Md.*18. Funeral director *L. H. Barnum*Address *20 Washington Street, Cambridge*19. April 29 1945 *James A. Meade* *James A. Meade* *Registrar*

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Oriental*City or town *Hooperville* (If outside city or town limits, write RURAL and give nearest town)Street No. *near Broad St and* (If Rural, give LOCATION)2. (a) If veteran, name war *WW*

3. (b) Social Security Number

217-03-5230

MEDICAL CERTIFICATION

20. DATE OF DEATH *April 26 1945* at *8th a.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1 1945 to *April 26 1945*and that I last saw him alive on *April 3 1945* *1945*Immediate cause of death *Carcinoma of Colon* DURATION*Multiples metastasis to liver*Due to *Const & Liver* *2 yrs*Due to Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE *James A. Meade, M.D.* M. D. or other Address *20 Washington Street, Cambridge* Date signed *April 27 1945*



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

03893

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:

County Dorchester

City or town Federalsburg - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

Near Finchville

How long in hospital or institution? -

3. (a) FULL NAME

Annie Evans

4. Sex

Female

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Jacob Evans

7. Birth date of deceased (mo., day, yr.)

About 1865

6.(c) If alive, give age - years

8. AGE:

About 80

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Dorchester County, Maryland

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Home

FATHER

12. Name

Charles Corrie

MOTHER

13. Birthplace

Dorchester County, Maryland

14. Maiden name

Rachel

15. Birthplace

Dorchester County, Maryland

16. Informant

Ola Collins

Address

Federalsburg, Maryland, R.R.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 12, 1945

(month) (day) (year)

Cemetery or crematory

Cokesbury Cemetery

Location

Near Federalsburg, Maryland

18. Funeral director

J. J. Trumpton and Son

Address

Federalsburg, Maryland

19. April 11, 1945 -

(Date rec'd by registrar)

Charles Hastings

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Dorchester

City or town Federalsburg - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Near Finchville

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

April 9

1945 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 6

1945 to

April 9, 1945

and that I last saw her alive on April 6, 1945

Immediate cause of death

Chronic myocardial Degeneration

5 yrs. +

Due to Age -

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William E. Harrison MD

M. D. or other

Harkock, Md.

Date signed 4/9/45

APR 23 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

03894

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Rural--Fishing Creek

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two Days

Hospital, institution, or street address where death occurred:

Home of Paul Fuegmann, Fishing CreekHow long in hospital or institution? —

3. (a) FULL NAME

Max R. Fuegmann

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife Auga C. Hager6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.)

March 27-1882

8. AGE:

Years

Months

Days

If less than one day

63

-

23

.hrs. — min. —9. Birthplace Plauen, Germany

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

Retired

FATHER

12. Name Gustav A. Fuegmann

MOTHER

13. Birthplace Germany

MOTHER

14. Maiden name Sophie Rex

MOTHER

15. Birthplace Germany16. Informant Mrs. Auga Hager Fruegmann

Address

Cairo, New York17. Cremation April 23, 1945
(Burial, cremation, or removal. Which?) Date thereof. April (month) 23 (day) 1945 (year)Cemetery or crematory Troy CrematoryLocation Troy, New York18. Funeral director LeCompte's Funeral Service

Address

Cambridge, Maryland19. 4-21-45 (Date rec'd by registrar)

John Mayer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New York County GreenCity or town Cairo

(If outside city or town limits, write RURAL and give nearest town)

Street No. Jerome Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war —

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 20, 1945, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive 00

19...

Immediate cause of death

Disease of Coronary

Due to

Arteritis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

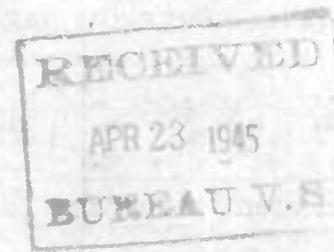
Means of injury

Injured at work?

13. SIGNATURE

M. D. or other

Address Cambridge, Md. Date signed April 21, 1945



Evidence for addition of sex is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3rd

03895

FILM NO. G 95 MAY 28 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County

Dorothy Tex
Cambridge Md Hospital

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

David Goswell

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widower

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

July 16 1867

6. (c) If alive, give age

years

8. AGE:

78

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

Stephen Goswell

13. Birthplace

ESTER HUDSON

14. Maiden name

15. Birthplace

16. Informal

not known

Address

Choptank

17. Burial

Date thereof

april 19 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Dorothy Tex

Location

Choptank

18. Funeral director

813 Willoughby

Address

East New Market

19. t-18

(Date rec'd by registrar)

19.

to

John May Jr. 20

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

county

Caroline

City or town

Preston

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

april 17

1945

at 7:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-14 1945, to April 17 1945

and that I last saw him alive on April 16 1945

Immediate cause of death

Coronary occlusion

DURATION

1 hour

Due to arteriosclerosis

Cardiovascular Disease

Due to

Other conditions Congestive

Heart failure

24 hrs

(Include pregnancy within 3 months of death)

Major findings or operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

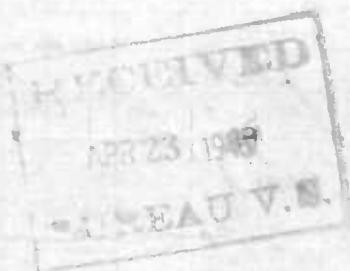
Eldridge H. Jeffry

M. D. or other

Address

Cambridge Md

Date signed



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 720

03896

CERTIFICATE OF DEATH

Reg. Dlat. No. 110

1. PLACE OF DEATH:

County Dorchester
City or town St. Michaels

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Thomas J. Hackett

4. SEX

Male

5. Color of face

white

6. (a) Single, married, widowed, or divorced

widower

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age — years

July 27 1856

8. AGE:

Years	Months	Days	If less than one day
88	9	8	hrs. min.

9. Birthplace

MD (Town, county, and state)

10. Usual occupation

11. Industry or business

Telghouse Hackett

FATHER

12. Name

13. Birthplace

MD

MOTHER

14. Maiden name

15. Birthplace

MD

16. Informant

Mrs Geo. Thompson

Address

St. MichaelsDate thereof April 20 1945

17. (Burial, cremation, or removal, which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

M. D. or other

24. (If rural, give LOCATION)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MD

County Dorchester

City or town

St. Michaels

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1945 at 3 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 20 1944 to April 20 1945and that I last saw him alive on April 10 1945 1945Immediate cause of death Acute myocarditis DURATION

Due to

Myocarditis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

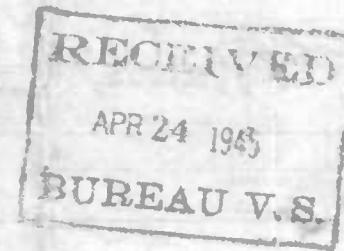
Means of injury Injured at work?

23. SIGNATURE

Address Date signed

M. D. or other

24. (If rural, give LOCATION)



PLEASE WRITE PLAINLY, WITH INK, FADING INK, Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

03897

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 Years

Hospital, Institution, or street address where death occurred:

Cambridge Maryland Hospital

How long in hospital or institution?

3. (a) FULL NAME

William S. Hubbert

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

8. (b) Name of husband or wife Mettie Lloyd Phillips

53

6. (c) If alive, give age 53 years7. Birth date of deceased (mo., day, yr.) Nov. 25, 18798. AGE: Years 65 Months 4 Days 25 If less than one day
hrs. _____ min. _____9. Birthplace Williamsburg, Va., Co., Md.
(Town, county, and state)10. Usual occupation Laborer11. Industry or business Shirt Factory12. Name Elighman Hubbert13. Birthplace Maryland14. Maiden name Amada Sherman15. Birthplace Maryland16. Informant Mrs. Wm. S. HubbertAddress 104 Glasgow St., Cambridge, Md.17. Burial Date thereof April 22, 1945
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory East New Market CemeteryLocation East New Market, Maryland18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland19. 4-21-45 (Date rec'd by registrar)Registrar John MacLaySignature John MacLayAddress Cambridge, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge (If outside city or town limits, write RURAL and give nearest town)Street No. 104 Glasgow St. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 20, 1945, at 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1, 1945, to April 20, 1945,and that I last saw him alive on April 20, 1945,

Immediate cause of death

Cerebral Hemorrhage

DURATION

7 weeksDue to ArteriosclerosisHypertension

?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John MacLay

M. D. or other

Address Cambridge, Maryland Date signed 4/21/45

RECEIVED
APR 25 1945
BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

03898

116

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH: Dorchester
County.....City or town..... Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 daysHospital, institution, or street address where death occurred: Cambridge Maryland HospitalHow long in hospital or institution? 4 days3. (a) FULL NAME Infant Hughes4. Sex Male 5. Color or race negro 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) April 25, 1945

6. (c) If alive, give age years

8. AGE: Years 0 Months 0 Days 4 If less than one dayhrs. 0 min. 09. Birthplace Cambridge, Dorchester, Md.
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name Roland Fletcher13. Birthplace Maryland14. Maiden name Florence Hughes15. Birthplace Maryland16. Informant Florence HughesAddress Eldorado, Md.17. Burial Date thereof April 30, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Washington CemeteryLocation Marlboro, Md.18. Funeral director Roland FletcherAddress Marlboro, Md.19. April 30, 1945 John M. J. M. Date signed
(Date signed by registrar) Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... County.....

City or town..... Eldorado
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 25 1945 to April 29 1945and that I last saw h..... alive on April 27 1945

Immediate cause of death.....

Prematurity

Due to.....

Miscarriage

Due to.....

Edema (maternal)

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

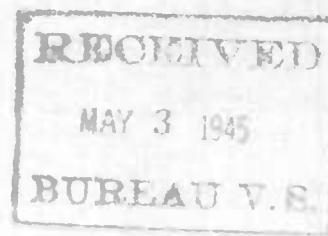
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William C. Harrison MD
M. D. or otherAddress Marlboro, Md. Date signed 4/30/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13/10

03899

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County... DorchesterCity or town... Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred:

1. Cedar St.How long in hospital or institution? -

3. (a) FULL NAME

Sherman T. Hurley

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

8. (b) Name of husband or wife Lina Watson7. Birth date of deceased (mo., day, yr.) June 12, 1868.

8. AGE: Years	Months	Days	It less than one day
76	11	1	hrs. min.

9. Birthplace Copeland, Dor. Co., Maryland
(Town, county, and state)10. Usual occupation Waterman

11. Industry or business

12. Name Thomas Hurley13. Birthplace Maryland14. Maiden name Gertrude Horseman15. Birthplace Maryland16. Informant William C. HurleyAddress Cambridge, Maryland17. Burial Burial Date thereof April 15, 1945
(Burial, cremation, or removal. Which?) Date (month) (day) (year)Cemetery or crematory Greenlawn CemeteryLocation Cambridge, Maryland18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland19. 4/14/45 19 41 John Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... DorchesterCity or town... Cambridge (If outside city or town limits, write RURAL and give nearest town)Street No... 1 Cedar St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1945 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 12, 1945 to April 13, 1945
and that I last saw h. alive on April 12, 1945

Immediate cause of death

ObstructionCardio - Pulmvascular disease

Due to

ObstructionCardio - Pulmvascular diseaseOther conditions none

(Include pregnancy within 8 months of death)

Major findings of operations none Date of op. noneAutopsy results none

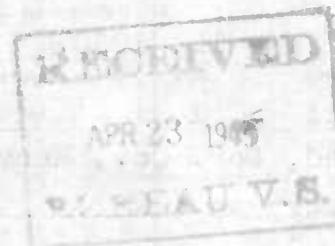
PHYSICIAN: Please underscore the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of noneWhere did injury occur? none (City or town) none (County) none (State)

Injured at home, farm, industry, public place (where?)

Means of injury none Injured at work? none23. SIGNATURE Sherman T. HurleyAddress Cambridge, Maryland Date signed 4/13/1945M. D. or other none



M

MARGIN RESERVED FOR BINDING

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1500

03900

CERTIFICATE OF DEATH

Reg. Dist. No. 111

1. PLACE OF DEATH

County

Dorchester

City or town East New Market

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mona Jackson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Colored Jordan

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.)

8. AGE: Years Months Days It less than one day

86 3 21 hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

House work

11. Industry or business

Kitchen Folly

12. Name

Mary Jackson

13. Birthplace

Dorchester

14. Maiden name

Mary Jackson

15. Birthplace

Dorchester

16. Informant

Mary Jackson

Address

East New Market

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or cemetery

18. Funeral director

Address

East New Market

19. April 22 1945 Elizabeth Smith

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland

County Dorchester

City or town East New Market

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 21 1945 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/18/45 19 to 4/24 19 45

and that I last saw her alive on 4/18/45 19

Immediate cause of death Chronic myocardial degeneration

Due to General arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE William C. Harrison MD

M. D. or other Harlock MD.

Date signed April 22 1945

Address





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-2

03901

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH: Dorchester

County.....

City or town..... Cambridge, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred: Cambridge Md. HospitalHow long in hospital or institution? 2 days

3. (a) FULL NAME

William Edgar Krouse

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

2 hrs. min.

9. Birthplace.....

Cambridge
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

Frederick Paul Krouse

MOTHER FATHER

12. Name..... Frederick Paul Krouse13. Birthplace Huntington Co. Pa.

14. Maiden name.....

Shelena Whitesel15. Birthplace Pa.

16. Informant.....

Frederick Paul Krouse

Address

Cambridge, Md.

17. Burial (Burial, cremation, or removal. Which?)

Date thereof April 10, 1945 (month) (day) (year)

Cemetery or crematory

Greenlawn

Location

Cambridge

18. Funeral director

Kenneth R. Krouse

Address

Cambridge, Md.19. 4-10-1945 (Date rec'd by registrar)

John Macay, M.D. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... DorchesterCity or town..... Cambridge (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 7

1945

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 6 1945 to April 7 1945 and that I last saw him alive on April 7 1945

Immediate cause of death

Atelectors lungs

DURATION

3 hoursDue to Pneumonia Examin mother
Proloose of cord.Due to PrematurityOther condition none

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

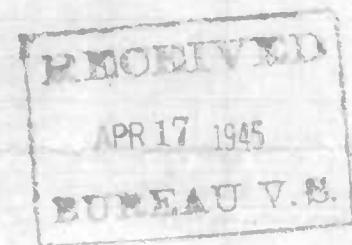
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M.D. or other
W. J. R. Krouse
Address Cambridge, Md. Date signed 4/9/45





N. B.—**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.** Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH 03902

1. PLACE OF DEATH

County Dorchester
Village or City Reliance

Length of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds. How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

2. FULL NAME Christiana H. Lankford If U. S. Veteran, specify WAR

(a) Residence: No. Reliance St. Ward
(Usual place of abode)

Registration Dist. No. 110

St. Ward

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

White

4. COLOR OR RACE

married

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

6. DATE OF BIRTH (month, day, and year)

7 - 30 - 1875

7. AGE

Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
<u>69</u>	<u>8</u>	<u>16</u>	

8. OCCUPATION

Housewife

9. INDUSTRY OR BUSINESS IN WHICH WORK WAS DONE, AS SILK MILL, SAW MILL, BANK, ETC.

Own home

10. DATE DECEASED LAST WORKED AT THIS OCCUPATION (MONTH AND YEAR)

Jan 1945 1945 50

11. TOTAL TIME (YEARS) SPENT IN THIS OCCUPATION

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Eldorado
Maryland

MOTHER FATHER

Joseph Sheatley

Eldorado
Maryland

Martha White

Eldorado
Maryland

Franklin Lankford
Reliance, Md.

18. BURIAL, CREMATION, OR REMOVAL

Placed Lakesbury, Md. Date Apr. 18, 1945

Methodist Cemetery
Reliance, Del.

April 16, 1945 Charles Hastings
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Apr 15

(Month)

(Day)

1937 5 1945
(Year)

22. I HEREBY CERTIFY, That I attended deceased from

Sept 9, 1942 to Apr 12, 1945

I last saw her alive on Apr 11, 1945; death is said to have occurred on the date stated above, at _____ m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Cerebral Hemorrhage
White Calsey at
Night

Date of onset

Other Contributory Causes of Importance:

Chronic Myocarditis

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of Injury _____, 19 _____

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of Injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) W. E. Johnson M. D.
(Address) Hyde Valley Rd.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	APR 23 1946	1 week ago
Run over by street car		1 week ago
Peritonitis	WED 24 APR 1946	3 days ago

Other contributory causes of importance:

Gallstones	May 1, 1923

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-2

03903

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County..... Dorchester

City or town..... Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... all of life

Hospital, institution, or street address where death occurred:

7 Slacum St.

How long in hospital or institution?

X

3. (a) FULL NAME

Gary Mack

4. Sex

5. Color or race

B.(a) Single, married, widowed, or divorced

male

colored

single

B.(b) Name of husband or wife.....

X

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

March 20, 1945

8. AGE:

Years

Months

Days

If less than one day

X

X

20

hrs.

min.

9. Birthplace..... Cambridge, Maryland

(Town, county, and state)

none

10. Usual occupation.....

X

11. Industry or business.....

William Batson

12. Name.....

Maryland

13. Birthplace.....

Beatrice Mack

14. Maiden name.....

Maryland

15. Birthplace.....

Beatrice Mack

16. Informant.....

Beatrice Mack

Address

7 Slacum St. - Cambridge, Md.

17. Burial

Date thereof

(Burial, cremation, or removal. Which?)

April 12/45
(month) (day) (year)

Cemetery or crematory.....

Cambridge

Location.....

Cambridge

18. Funeral director.....

Severst & Sons

Address

Cambridge

19. (Date rec'd by registrar)

19. 4-11-45

(Date signed)

John Mack, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Dorchester

City or town..... Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 7 Slacum St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 9 1945 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

X 19..... to X 19.....

and that I last saw h..... alive on X 19.....

Immediate cause of death.....

Congenital Malformation
of the heart

Due to..... X

Due to..... X

Other condition..... X

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

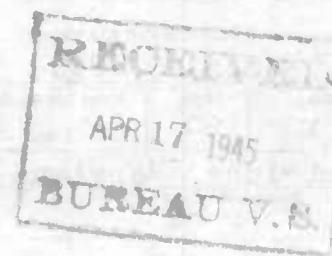
Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Cambridge, Md.

Date signed..... Apr. 9/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46-3

03904

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County..... Dorchester

City or town..... Rural Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Life

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Cambridge RFD #3

How long in hospital or institution?

3. (a) FULL NAME

Henry Clay Marshall

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife.....

Emma J. Peters

7. Birth date of deceased (mo., day, yr.)

Feb. 9, 1871.

6.(c) If alive, give age..... 71 years

8. AGE: Years

74

Months

1

Days

28

It less than one day

hrs.

min.

9. Birthplace.....

Nr. Cambridge, Dor. Co., Md.

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

Dirt

MOTHER FATHER

12. Name..... George N. Marshall

13. Birthplace..... Maryland

14. Maiden name.....

Sarah J. Marshall

15. Birthplace.....

Maryland

16. Informant.....

Mrs. Carroll Thomas

Address

Cambridge, Maryland.

17. Burial.....

Date thereof April 9, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Speddans Cemetery

Location..... James, Maryland.

18. Funeral director.....

LeCompte Funeral Service

Address

Cambridge, Maryland.

19.

4-9-1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Dorchester

City or town..... Rural Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No..... RFD # 3

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

April 7, 1945, at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 20

1945, to April 7, 1945

and that I last saw him alive on April 6, 1945

Immediate cause of death.....

Gastro Intestinal

malignant Growth

Due to.....

DURATION

Due to.....

Other conditions.....

Profound Leucocytosis

Anemia

2 grs.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

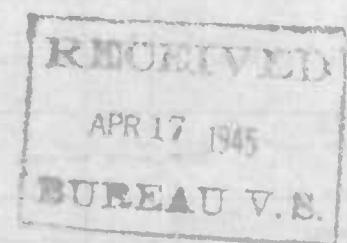
Means of injury.....

Injured at work?

23. SIGNATURE.....

Elderider H. H. Marshall, M. D. or other

Address..... Cambridge, Md. Date signed..... 4-9-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5-2

03905

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:

County

Dorchester County
Crags Maryland

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Serena McReady

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Colored

Married

6. (b) Name of husband or wife

Orlie McReady

7. Birth date of

deceased (mo., day, yr.)

Mar. 9, 1896

(6. c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

49

09

1

7

hrs.

min.

9. Birthplace

Crags Md.

(Town, county, and state)

10. Usual occupation

Labor

11. Industry or business

FATHER

William A. Johnson

MOTHER

Crags Md.

13. Birthplace

Crags Md.

14. Maiden name

Julia MacReady

15. Birthplace

Crags Md.

16. Informant

Julia Jenkins

Address

6 School House Lane

Burial

Crags Cemetery

Date thereof April 12 1945

(month) (day) (year)

Cemetery or crematory

Crags Cemetery

Location

Beach Ground

17. Funeral director

J. H. B. Agency

Address

207 W. Washington St.

18. Funeral director

J. H. B. Agency

Address

207 W. Washington St.

19. Apr. '45

19. X. S.

(Date rec'd by registrar)

J. W. Meade

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Dorchester

City or town Crags

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH

Apr. 12, 1945

19 X. S. at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 12, 1945,

19 X. S. to Apr. 12, 1945,

and that I last saw her alive on Apr. 12, 1945.

Immediate cause of death Acute Endocarditis

DURATION

1 M. 5.

Due to Acute Rheumatic Fever

2 M. 5.

Due to

Other conditions Chronic Rheumatic Carditis

5 yrs.

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

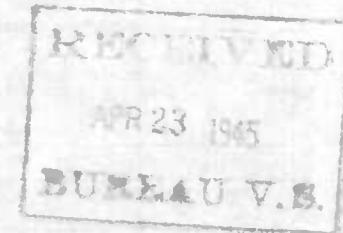
Injured at work?

23. SIGNATURE

Amelia W. Meade M.D.

M. D. or other

Address Fishing Creek Rd. Date signed Apr. 10/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

03906

CERTIFICATE OF DEATH

Reg. Dist. No. 116 119

1. PLACE OF DEATH:

County Dorchester

City or town Bishops Head

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Drowned near Home

How long in hospital or institution? -

3. (a) FULL NAME

Victor S. Pritchett

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	White	Married

6. (b) Name of husband or wife Florence E. Murrell

6. (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1897.

8. AGE:	Years	Months	Days	If less than one day
	47	7	0	hrs. min.

9. Birthplace Bishops Head, Dor. Co., Md.

(Town, county, and state)

10. Usual occupation Waterman

11. Industry or business

FATHER	12. Name	Zebelou Pritchett
	13. Birthplace	Maryland

MOTHER	14. Maiden name	Martha W. Pritchett
	15. Birthplace	Maryland

	16. Informant	Mrs. Victor Pritchett
	Address	Bishops Head, Maryland.

17. Burial	Date thereof	April 15, 1945
	(month)	(day)
	(year)	

Cemetery or crematory	St. Thomas Cemetery
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Location	Bishops Head, Maryland.
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18. Funeral director	LeCompte's Funeral Service
----------------------	----------------------------

Address	Cambridge, Maryland.
---------	----------------------

19. (Date rec'd by registrar)	apr 15 1945	W. E. Pritchett
-------------------------------	-------------	-----------------

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town Bishops Head

(If outside city or town limits, write RURAL and give nearest town)

Street No. Bishops Head

(If rural, give LOCATION)

2. (a) If veteran, name war -

3. (b) Social Security Number -

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1945 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Drowning - Accidental 4

Due to

Due to X

Other conditions X

(Include pregnancy within 3 months of death)

Major findings of operations X

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of April 13 1945

Where did injury occur on Harbor Island (City or town) Maryland (County) (State)

Injured at home, farm, industry, public place (where?) on Harbor Island

Means of injury Drowning Injured at work? Yes

23. SIGNATURE Dr. W. Shire, D. M. D. Esq.

M. D. or other

Address Cambridge - Md. Date signed April 14 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

03907

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester

City or town Taylors Island

(If outside city or town limits, write RURAL and give nearest town)

Life

How long in above place of death?

Hospital, institution, or street address where death occurred:

Home -- Taylors Island

How long in hospital or institution?

3. (a) FULL NAME

Augustus c. Ruark

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife

Mattie Ruark (Deceased)

7. Birth date of deceased (mo., day, yr.)

April 18, 1872

6. (c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

72

11

21

hrs.

min.

9. Birthplace Taylors Island, Dor. Co., Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Dirt

MOTHER

FATHER

John W. Ruark

13. Birthplace

Maryland

14. Maiden name

Jane Adams

15. Birthplace

Maryland

16. Informant

John Ruark

Address

Taylors Island, Maryland.

17. Burial

Date thereof April 11, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Brick Church Cemetery

Location Taylors Island, Md.

18. Funeral director

LeCompte's Funeral Service

Address Cambridge, Maryland.

19. (Date rec'd by registrar)

4-10-45

John Macdonald

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Dorchester

City or town Taylors Island

(If outside city or town limits, write RURAL and give nearest town)

Street No. Taylors Island

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2d. DATE OF DEATH

April 9, to 45, at 10:20 A.M.

2d. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 6, 1945, to April 9, 1945,

and that I last saw him alive on April 8, 1945.

Immediate cause of death

Cerebral Hemorrhage 4 days

Due to Hypertension 1/2

Due to

Other conditions Bronchitis 1/2

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

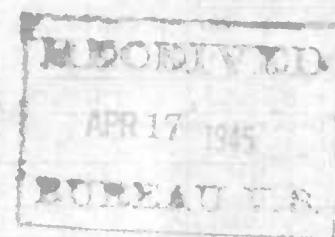
Means of injury

Injured at work?

23. SIGNATURE

Dr. K. Stinson, M.D. M.D. or other

Address Cambridge, Md. Date signed Apr. 1945



M

MARGIN RESERVED FOR BINDING

S

T

VS A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2020

03908

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester

City or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Fannie Estella St. Clair

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Negro Married

H. M. St. Clair

6. (b) Name of husband or wife

6. (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) June 26, 1877

8. AGE: Years Months Days If less than one day
67 9 10 hrs. min.9. Birthplace Crisfield, Som. Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name John Wilson

13. Birthplace Crisfield, Som. Co. Md.

14. Maiden name Harriet (Unknown)

15. Birthplace Crisfield, Som. Co. Md.

16. Informant H. M. St. Clair

Address Cambridge, Md.

17. Burial 8 Date thereof Apr. 10 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Waugh Cemetery

Location Cambridge, Md.

18. Funeral director H. M. St. Clair and Son

Address Cambridge, Md.

19. 4-9-1945 Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. 308 Muir Street

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1945 at 5:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1945 to April 6 1945

and that I last saw her alive on April 6 1945

Immediate cause of death

Cerebral Hemorrhage

DURATION

1 day

Due to Hypertension

1944

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

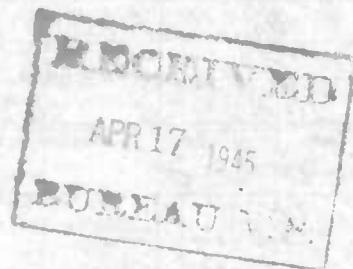
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Carroll M. St. Clair, Md. M. D. or other

Address One Cedar St. Date signed 4-9-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

03909

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

Dorchester

County

City or town

Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Russell J. Tall

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Married

6. (b) Name of husband or wife

Lula Lee Stewart

7. Birth date of deceased (mo., day, yr.)

5/10/1894

6. (c) If alive, give age

47 years

8. AGE:

Years

Months

Days

If less than one day

50

11

7

hrs. min.

9. Birthplace

Cambridge

(Town, county, and state)

10. Usual occupation

Seaman

11. Industry or business

John J. Tall

MOTHER FATHER

Dor Co

14. Maiden name

Alexina Harper

Dor Co

16. Informant

Herbert Tall

Address

Cambridge, Md.

17. Burial

4/20/45

Date thereof

(month)

(day)

(year)

Cemetery or crematory

Dorchester Memorial

Location

Cambridge, Md.

18. Funeral director

Kenneth R. Thomas

Address

Cambridge, Md.

19. 4-18-

John Moore, M.D.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Cambridge

Street No.

Dorchester

213 Choptank Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 17 1945 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Die 1944 to April 17 1945

and that I last saw him alive on April 17 1945

Immediate cause of death

Central Hemorrhage

DURATION

6 hrs

Due to

Asthma Bronchial

6 to yrs

Due to

Cardiac Dilatation

2 days

Other conditions

Cardiac Dilatation

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

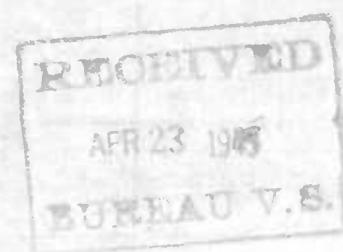
23. SIGNATURE

J. K. Shire, D.P.M. Exam.

M.D. or other

Address

Cambridge, Md. Date signed April 18, 1945





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

03910

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH: Dorchester
 County: Cambridge, Md.
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 22 years
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

3. (a) FULL NAME Frank T. Thorne

4. Sex <u>Male</u>	5. Color or race <u>white</u>	6.(a) Single, married, widowed, or divorced <u>married</u>	
6.(b) Name of husband or wife <u>Lillian May Cuddy</u>		6.(c) If alive, give age <u>71</u> years	
7. Birth date of deceased (mo., day, yr.) <u>April 18 - 1867</u>			
8. AGE: Years <u>78</u>	Months <u>0</u>	Days <u>11</u>	If less than one day

9. Birthplace Wayside, Ohio
 (Town, county, and state)

10. Usual occupation Cabinet Vault Mfr.

11. Industry or business Burial Vaults

FATHER	12. Name <u>Alexander Thorne</u>
MOTHER	13. Birthplace <u>Ohio</u>

14. Maiden name <u>Throckmorton</u>
15. Birthplace <u>Ohio</u>

16. Informant <u>Frank C. Thorne</u>
Address <u>Cambridge, Md.</u>

17. Burial <u>Burial</u>	Date thereof <u>May 1, 1945</u>
(Burial, cremation, or removal. Which?)	(month) (day) (year)

Cemetery or crematory <u>Dorchester Memorial Park</u>

Location <u>Cambridge, Md.</u>

18. Funeral director <u>Kenneth R. Thorne</u>
Address <u>Cambridge, Md.</u>

19. (Date rec'd by registrar) <u>May 1st 1945</u>	John Macy Jr. M.D. <u>Registrar</u>
--	-------------------------------------

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Cambridge, Md.
 Street No. 209 Race St.
 (If rural, give LOCATION) none

2.(a) If veteran, name war none

3. (b) Social Security Number none

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 29 - 1945 at 7:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945 to Apr 29, 1945 and that I last saw him alive on Apr 28, 1945

Immediate cause of death Concussion

Due to Cabinet - Rival

Due to Wayside Drive

Due to 4th flr.

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

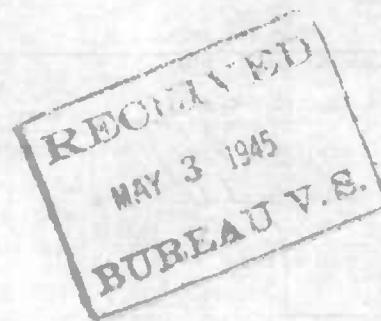
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Thorne M. D. or other

Address Cambridge, Md. Date signed 4-30-1945



PLEASE WRITE PLAINLY, WITH UNEVEN INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore



CERTIFICATE OF DEATH

03911

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester

City or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

87 years

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Home

How long in hospital or institution?

3. (a) FULL NAME

Eben W. Wheatley

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widower

6. (b) Name of husband or wife

A. Mae Wheatley

Deceased

6. (c) If alive, give age

67

years

7. Birth date of deceased (mo., day, yr.)

April 15, 1859

8. AGE:

Years 86

Months 11

Days 24

If less than one day

9. Birthplace

East New Market, Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farm

MOTHER FATHER

12. Name

Elihu Wheatley

13. Birthplace

East New Market, Md.

14. Maiden name

Mary Stevens

15. Birthplace

East New Market, Md.

16. Informant

Eben W. Wheatley (Son)

Address

East New Market, Md.

17. Burial

4-11-45

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

East New Market Cemetery

Location

East New Market, Md.

18. Funeral director

H. H. Hirzel

Address

Wilmington, Del.

19. (Date rec'd by registrar)

4-10-45

1945

John Macay, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Dorchester

City or town East New Market

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(d) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 8

1945

at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1, 1945

to

4/8

1945

and that I last saw h. i. t. alive on 4/8

1945

Immediate cause of death

Myocardial Failure

DURATION

4 days.

Due to Hypertensive cardiovascular

disease

Due to Senility

Bronchial Asthma

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: home.

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John Macay, M.D.

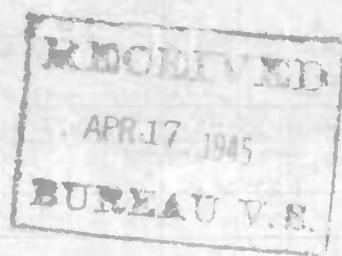
or other

Address

Cambridge Md

Date signed

4/10/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-6

03912

CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Wallace Milton Wheately4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Mary Wheately6. (c) If alive, give age 34 years7. Birth date of deceased (mo., day, yr.) April 17 18948. AGE: Years 46 Months 11 Days 24 If less than one day hrs. min.9. Birthplace Beckwith Pa. Co. Pa.

(Town, county, and state)

10. Usual occupation Chapman

11. Industry or business

12. Name John Jackson13. Birthplace Dorchester Co. Md.14. Maiden name Clara Sherr15. Birthplace Dorchester Co. Md.16. Informant Mary WheatelyAddress 208 Penn St Cambridge17. Burial Burial Date thereof Apr 15 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Waugh CemeteryLocation Cambridge, Md.18. Funeral director H. M. Blair and SonAddress Cambridge, Md.19. Date rec'd by registrar 4-11-1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. 208 Penn St

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945, at 4:54 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 22 1945, to April 11 1945, and I last saw her alive on April 11 1945.Immediate cause of death Sarcoma left hip

DURATION

4 mo

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Carroll M. St. Clair, M.D.

M. D. or other

Address One Cedar St. Date signed 4-17-1945

